Diverting Mentally Ill Youth from the Juvenile Justice System

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Outline

- The Problem and a Framework for Potential Action
- Definitions: Diversion, Screening, Assessment, Disposition
- Potential Points of Diversion
- Mood Disorders in Children and Adolescents
- Impulse and Behavioral Disorders
- Anxiety, Post Traumatic Syndromes and Psychosis
- Harm Done by Our Current System
- The Importance of Family and Connectedness
- Some Recommendations

Identified Population

- Children 8-18 who have been charged, arrested or are at imminent risk of being arrested or delinquent behavior
- This is clearly an underserved population that is at extremely high risk
- Children of poverty and color are grossly overrepresented
- Some have said that the Juvenile Justice Institutions have become the de facto Mental Health System (dumping grounds) for these children (e.g. Fox Butterfield New York Times)

Desired Outcomes:

- Early intervention for mentally ill youth at high risk
- Diversion of mentally ill children from the juvenile justice system in accord with the values of the MHSA
- When diversion is not possible children should be directed to appropriate treatment which includes family
- Treatment and Assessment should occur under the least restrictive or harmful conditions and the natural (re-entry) community whenever possible
- Mental Illness should taken into account in disposition
- Should be differentiated issues of forensic competence or culpability for the purpose of this discussion

Strategy:

- Systematic, reliable and valid screening for mental illness –repeated when necessary
- Quality assessments (different than forensic evaluation)
- Appropriate treatment planning with consideration of age, gender, family, connectedness, verbal ability, other
- Active facilitation of multidisciplinary transfer of juvenile information (with appropriate safeguards)
- Inter disciplinary knowledge transfer (there is a big difference between what we know and what we do)
- Active facilitation of workable models of interdisciplinary collaboration with special attention to communication (including vocabulary) across systems

This Strategy:

- Increases information available to decision makers
- Will lead to enhanced screening and better assessment (includes family and sub culture wherever possible)
- Improves access for a high risk population
- Reduces impact of trauma
- Strengthens protective factors
- Is cost effective and sustainable
- Can be adapted to local conditions and concerns
- Decreases harm done to our children

The Problem

- The prevalence of mental illness is very high in juvenile offenders
- Many disorders have their onset in childhood and persist into adulthood. Left untreated, many children get worse into adulthood
- Many psychiatric disorders present as disordered conduct in children
- Many children develop co-morbid conditions if untreated

The Problem (2)

- Within 2 years, 50% of emotionally ill school dropouts end up in the juvenile justice system
- Formal screening tools are applied only for probationary screening purposes (MAYSI-2)
- Formal and reliable screening assessment systems are most often poor to non-extant for *mentally ill* children (as currently applied)
- For many children our current juvenile justice system causes harm

First Do No Harm

- Many correctional practices (e.g. Boot camps, Scared Straight) are harmful to kids *without* mental illness
- Peer effects (e.g. congregation of delinquents) can lead to increased identification as a delinquent subsequent criminality
- Sometimes children with mental illness are put in solitary confinement for days/weeks at a time
- Intergenerational Involvement is not exceptional
- There is gross racial, ethnic, and socioeconomic unfairness (disparity)
- There is often a disregard of family needs
- There is the potential for net widening

W.H. Auden

September 1, 1939

I and the public know
What all schoolchildren learn,
Those to whom evil is done
Do evil in return.

What the Judges Think

- 86% believe that children are being shunted from the mental health system
- 70% believe that 15% or more of juvenile defendants are retarded
- The vast majority complain about their communication/relationships with mental health professionals
- Virtually all of them want more alternatives for juveniles with mental illness

Diversion: an operational definition

- Decreased reliance on formal detention and incarceration for mentally ill offenders
- Probation involvement only when necessary
- Sanctions are not exclusively punitive, focused on retribution or the deterrence of others
- Decreased reliance on institutional correctional programs for mentally ill offenders
- Interventions consider the needs of the child and their family (family involvement is vigorously encouraged)
- Increased focus on treatment and developmentally appropriate services (esp. culturally appropriate community based alternatives and resources)

Potential Points of Diversion

Some other definitions:

- Screening (e.g. Massachusetts Youth Screening Inventory-2)
- Assessment (must include family input)
- Forensic Evaluations are not the focus of today's discussion
- Treatment must foster resilience, recovery and positive connectedness (Heart, Mind, Body and Soul-for most ethnic minorities)
- Sanctions and Dispositions (sentencing)

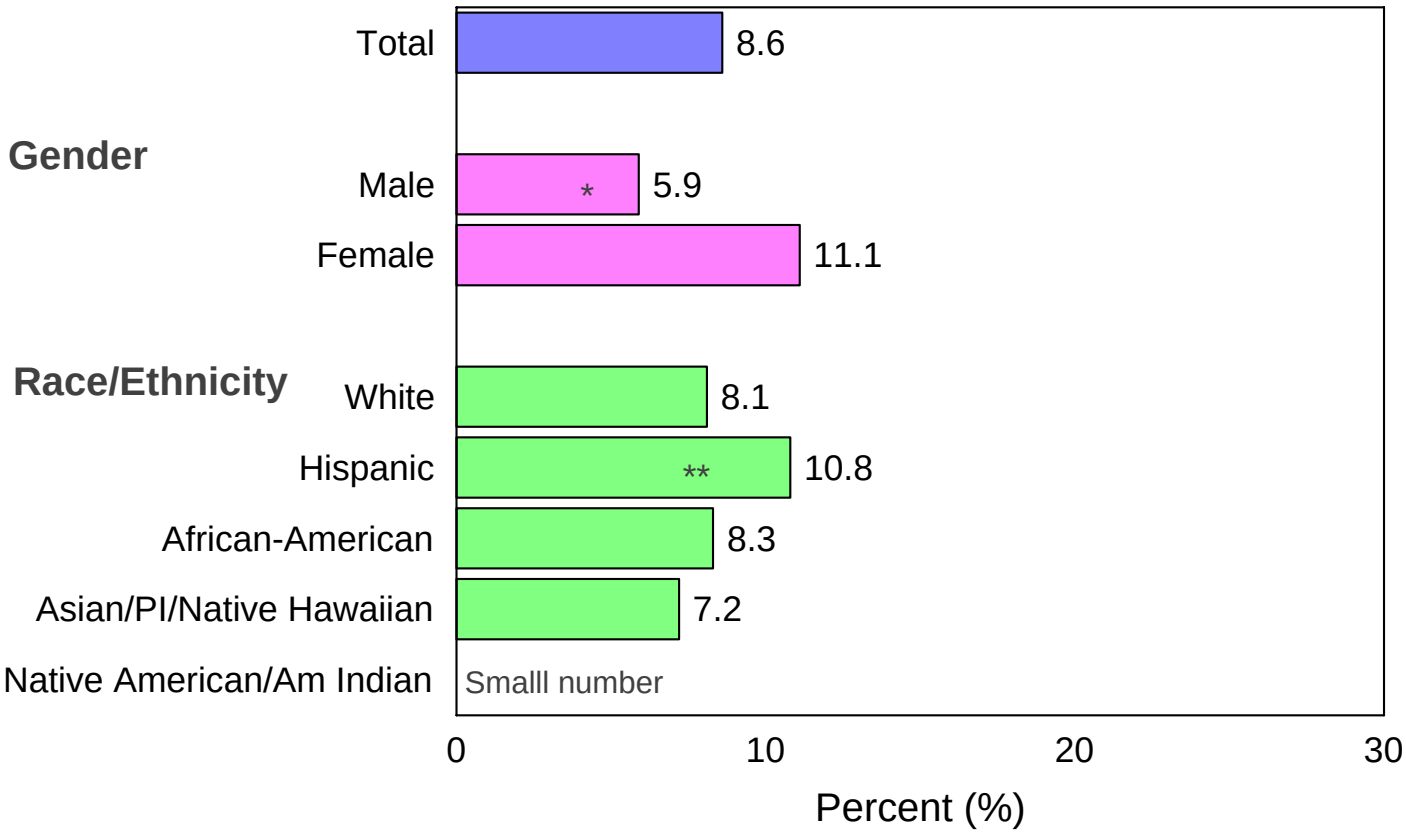
LIKE FEVER, DISRUPTIVE BEHAVIOURS ARE A NON-SPECIFIC SYMPTOM

Mood Disorders in Detained Children and Adolescents

- Very common (at least 20-30%)
- Irritability replaces Depressed Mood
- Acting out is common but not always present
- Capacity and willingness to verbally articulate despair is often limited
- Diagnosis is often missed by cursory exam
- Treatment is very effective

High School Students[1] Who Attempted Suicide during past 12 months by Gender and by Race/Ethnicity

Santa Clara County, 2002



1: 9th and 11th grade students were sampled; * Significantly different from females; ** Significantly different from Whites and Asian/PI

Source: Santa Clara Valley Health & Hospital Systems; Public Health Department; Planning & Evaluation; Data Management & Statistics; California Healthy Kids Survey, 2002.

Bipolar Disorders in Children

- Earlier onset than previously assumed
- Mania, depression, mood swings
- Sometimes cycles rapidly
- Grandiosity and irritability
- Impulsivity and Impaired Judgment
- Hyper-sexuality
- Strong genetic component
- Very treatable

Impulse and Behavioral Disorders

- ADHD, Oppositional Defiant and Conduct Disorders
- Extremely common in juvenile justice
- Median age of onset is 11 years in general population
- Associated with subsequent substance abuse
- Antisocial (incipient socio-pathic) character is extremely rare
- Most disorders are quite treatable

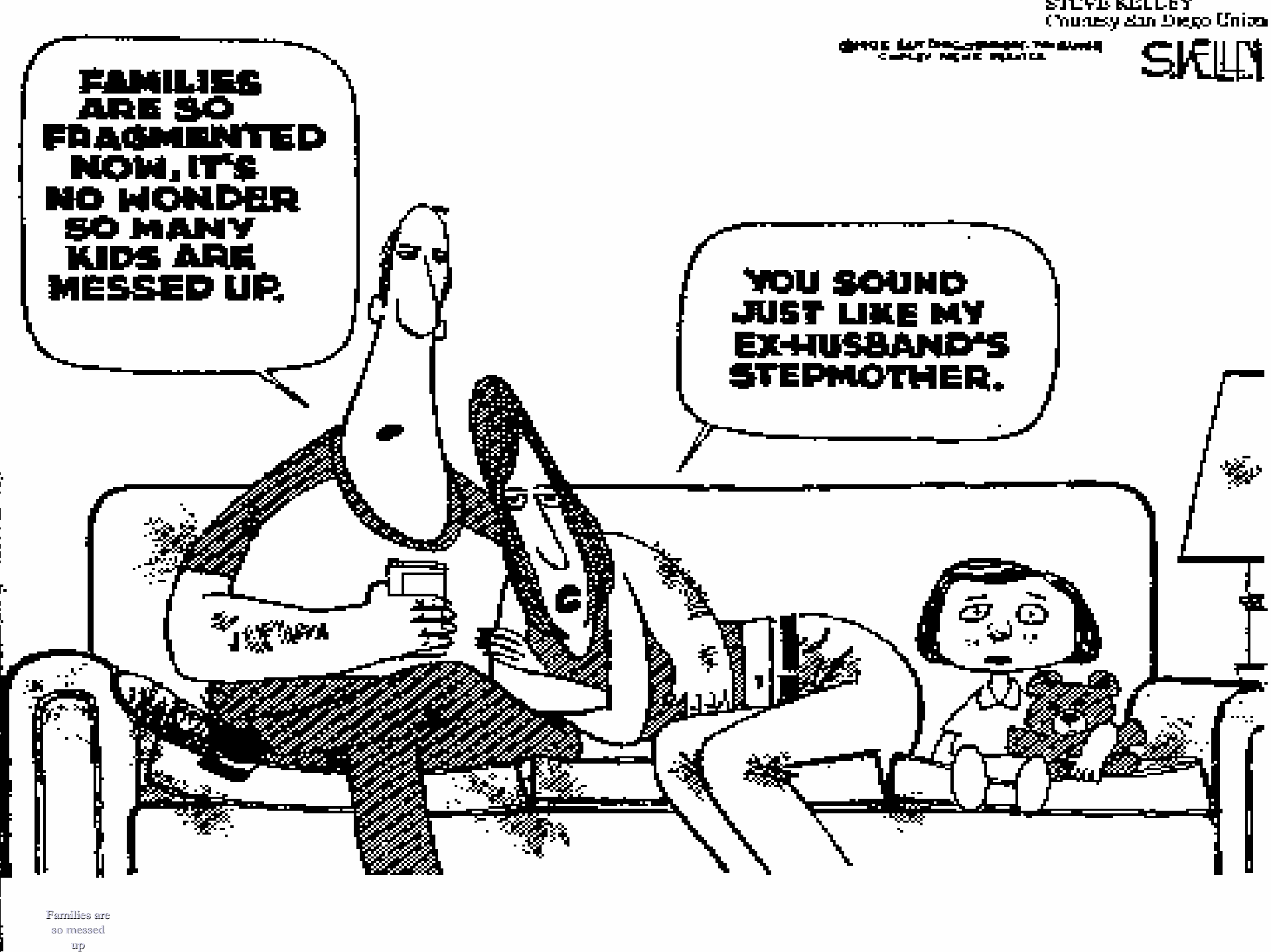
Anxiety Disorders

- Very common (at least 20-30%) in detained youth
- Considerably higher incidence in girls
- Some studies include Separation Anxiety
- Post Traumatic Stress syndromes are especially common in girls
- 80% of Girls report being molested, raped or in fear of being raped

Psychotic Disorders

- Especially problematic in juvenile justice context
- Prodromal syndromes (earliest onset of symptoms) occur earlier than previously believed
- Often treated with isolation (protracted solitary confinement)
- Probation staff have very little (if any) training
- Absolutely devastating and terrifying for child
- Suicide is a very real risk

The Importance of Family and Connectedness



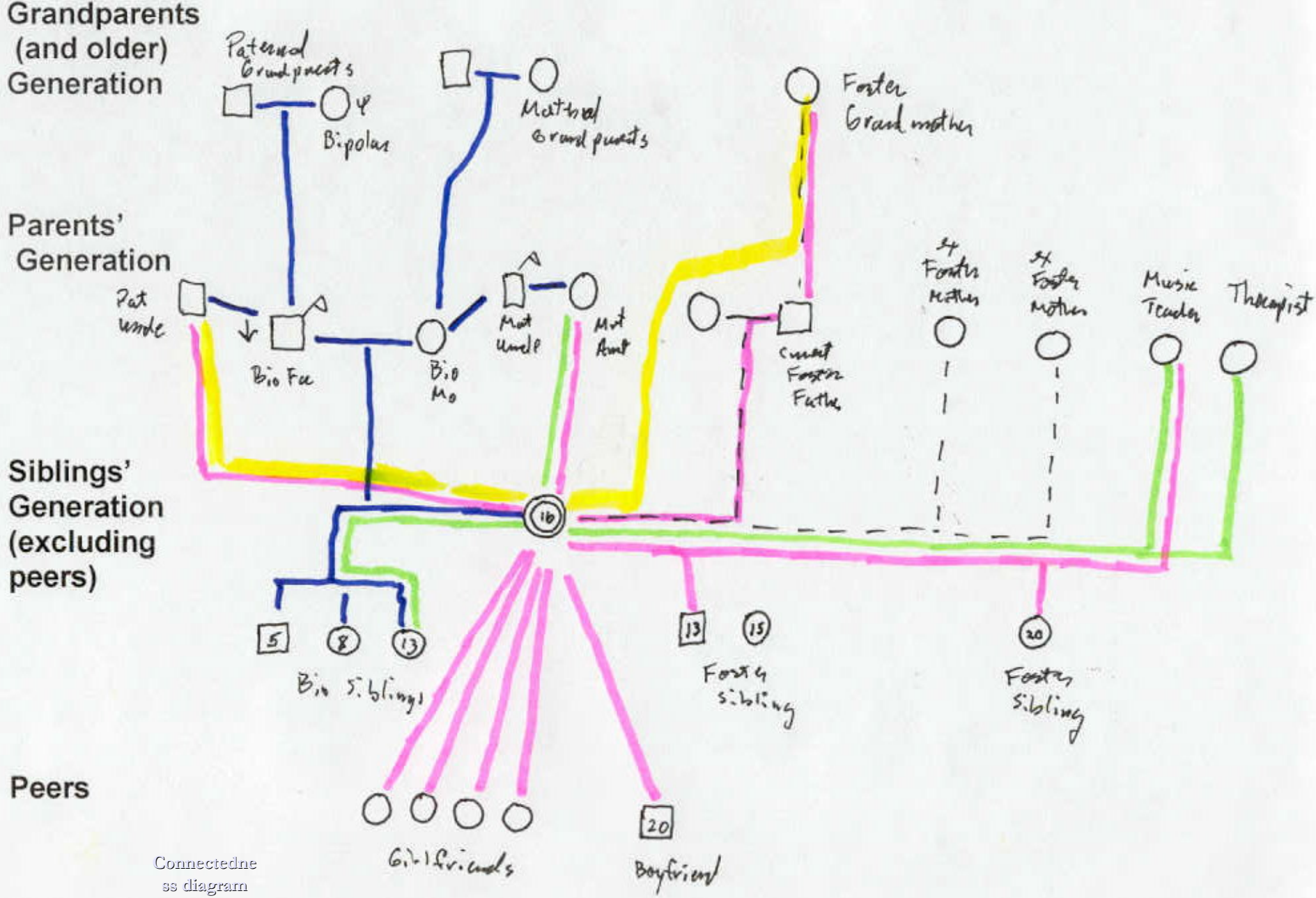
Families are so messed up

Imagine Taking Care of this Plant

D. Arredondo / Ofiice of Child Development and Mental Healh

Dimensions of Connectedness (key for resilience and recovery models)

- **HEART** - Who do you love? Who loves you? Who do you want to love you? Who is missing you?
- **MIND**-Who teaches you? What are you learning? Who do you teach? What do you think about?
- **BODY**- Who shares your blood? Does anybody share your body? Who provides you with food and shelter?
- **SOUL**- To what or whom is your soul connected? What are your passions? What matters to you? What do you value? To what are you connected that is bigger than you?



Connectedness diagram

Color Code for Lines

- Blue is for the blood that runs in the veins (body)
- Red is for the heart that bleeds
- Green is for the fertile and creative mind
- Yellow is for the light of the soul

Some recommendations

- Screen ALL serious candidates for probation or detention using sensitive and reliable screens
- Automatically search community mental health database for prior involvement
- When indicated, require formal assessments of good quality for mental illness-always include family
- Clarify all points of potential diversion and design mechanisms for detection wherever possible

Recommendations (2)

- Active facilitation of multidisciplinary transfer of information (with appropriate safeguards)
- Inter disciplinary transfer of knowledge (there is a big difference between what we know and what we do)
- Active facilitation of workable models of interdisciplinary collaboration with special attention to communication (including vocabulary) across systems---especially the judiciary, probation and mental health departments

Recommendations (3)

- Consider Juvenile Mental Health Courts
- Consider Juvenile Mental Health Court Clinics
- Consider Diagnostic Receiving Centers
- Active encouragement of the development and application of evidence based and culturally competent assessment and treatment services
- Give our judges more alternatives for our children who are mentally ill youth
- First do no harm

About The Office of Child Development and Mental Health

- Nationally: Pro Bono consultation and technical assistance to the Family Court (Dependency) and Juvenile Delinquency Court judiciary
- Nationally: Assistance with program design
- Speakers bureau
- In California: Pro Bono consultation to Juvenile Probation Departments, the Judiciary, and County Mental Health Departments regarding issues of mental health and juvenile justice/dependency court

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